

CRA After Action Review Call: H1N1 Vaccine Doses Administered Event Webinar Transcript

**January 20, 2010
1:00 pm CT**

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode until the question and answer period. If you would like to ask a question at that time please press star 1 on your touchtone phone.

Today's conference is being recorded. If you have any objections you may disconnect at this time. I would like to turn over the meeting to Barb Nichols.

Barb Nichols: Thank you. Good afternoon to all of you. Happy New Year and welcome to this After Action Review call. As the Operator indicated, I am Barb Nichols and I am the current Health Scientist Lead for the CRA program.

Joining me today are my colleagues from the Immunization Services Division Jeanne Tropper, Warren Williams, Howard Hill and members of the CRA Data Analysis and Outreach Team from Northrop Grumman, McCain Consulting and SRA International.

On behalf of everyone involved here today, I would like to thank you all for your participation, cooperation and support in this important pandemic influenza initiative. This event has demonstrated a remarkable collaboration between local, state and Federal levels.

Today we will be reviewing recent H1N1 vaccine doses administered event. We will address the H1N1 doses administered, the After Action review. We would like to have the discussion with allowing for questions and answers and we would really like your feedback on your experiences with the event.

And we will be providing you with information on the upcoming results sharing Webinar in February.

The purpose of this call is to gather feedback from the Project Areas about your experiences with weekly reporting of H1N1 doses administered counts to the CRA system.

Along with sharing the results, we would like to discuss what went well and what could have been done better during the planning and execution of the doses administered response.

This feedback process provides us with an opportunity to hear recommendations and suggestions that will assist with our evaluation in future planning efforts.

With that let me begin with the background of why CRA was used to monitor doses administered. The National Strategy for Pandemic Influenza: Implementation Plan calls for monitoring appropriate use of scarce pre-pandemic and pandemic influenza vaccine.

To accomplish this, the Project Areas were asked to track pandemic influenza vaccine doses administered at the individual patient level and then were asked to send a data subset weekly to the CDC.

CRA was used to track initial doses administered which is a critical component of safety and to ensure targeted groups were reach. The Countermeasure and Response Administration, CRA, was modified to provide flexible ways for Project Areas to report vaccine doses administered.

Now let's move onto discussing the H1N1 doses administered results. The total reported doses administered for the period of October 3 to November 21 as of January 1, 2010, were over 14.7 million doses. Additional Project Area reporting statistics include as of November 21, 57 of the 62 Project Areas which represents 92% submitted data on time.

The average lag time was two to four weeks for receiving full updated counts. As of January 1, Project Areas reported administering 35% of the doses of H1N1 vaccine that they had been shipped.

Counts were submitted according to the ACIP age group guideline. The total doses administered in each of these age groups include, and I believe you have this information in front of you. For the 6 to 23 month age group, the doses administered were 842,458, in the 24 to 59 months age group, 1,718,372 doses, for the 5 to 18 year old age group, 5,246,737, in the 19 to 24 year old age group, 913,680, in the 25 to 49 year old age group, 3,663,911, in the 50 to 64 year old age group, 1,827,796, and in the 65 year old age group, 575,841, all totaling over 14.7 million doses.

The Project Areas in order to meet reporting requirements were responsible for submitting counts of H1N1 vaccine doses administered for each reporting period based on the MMWR Sunday through Saturday week. The deadline for reporting was Tuesday by 11:59PM of the Project Area's respective time zone.

Project Areas were also responsible for submitting counts of H1N1 vaccine doses administered according to the age group discussed above. Submitting those number count - category which was also required, it was either a first flu shot, a second flu shot or a flu shot unknown.

Now let's move on to the After Action Review. The purpose of this standardized instruction review is to evaluate the event objectively without pointing out what went right or wrong.

We would rather focus on the occurrence as what was planned to happen would actually might happen. So there our evaluation is measured against predetermined goals.

For the ease of our discussion, we would like to divide the review into two periods, the two periods being the prevent period which was from May through September of 2009 and the event period beginning in October lasting through November 21.

We have three questions that we will use to guide our discussion for these periods. They are: What did we plan? What was expected to happen? What actually happened? And why did this happen?

So moving onto the discussion about the pre-event period which was May through September. What was planned? What did we expect to happen?

We asked that the points of contact from the 62 Project Areas identify and confirm who their points of contact would be for that area by May 31. And we asked our partner outreach liaisons to have an initial H1N1 plan discussion with your CDC CRA point of contact by the end of July.

For Option 1 users, we asked you to determine the content format for your system when used and to select a method your system would use to transfer the information by July 31.

We also asked you to develop any code necessary to create the selected file format and transport the file to CRA by August 21. And lastly, to send a test file for evaluation after development of code by September 4.

For the Option 2 and 3 users, we asked you to determine the method by which your Project Area would enter data into CRA by September 8th. If entering data at the clinical or local level, we asked you to ensure that all clinics entering data into the Web based CRA system would have been added and assigned to the **Novel Influenza H1N1-09** event by September 1.

And we also asked you to ensure that all users who would be accessing or entering data into the Web based CRA system would have been assigned to the appropriate organization or clinic by September 11. And you were asked to have digital certificates for all users by September 11.

On the CDC end, we were responsible for providing training to the new points of contact. So let's talk about the results, what actually happened.

Following the Doses Administered Exercise (DAX) 2008 exercise, the CRA team was focused on running a similar exercise for '09. However when the H1N1 strain drug CDC decided that the CRA efforts and resources would be better used to track doses administered for the H1N1 vaccine.

Event preparation began which provided CDC with enough time for planning. The initial planning activities involved identification and confirmation of points of contact which was done on time. Many Project Areas had the same point of contact from last year and new POCs caught on quickly.

With the Option 1 users, content determination transfer method developing code and submitting test file activities all occurred close to target. Nine of 24

representing 37.5% designated Option 1 users submitted an Option 1 file by 9/4.

Option 1 users submitted a test file by 9/25. Training and refresher Webinars included reminders to Option 1 users of process and technical insecurity considerations.

With Option 2 and 3 users, determining the data entry method, setting up clinics and ensuring users were associated with correct event and clinic activities all occurred close to target. Training and refresher Webinars included reminders to Option 2 users of process, technical and security considerations.

With the digital certificates, for those who had been through the SDN digital certificate process before, obtaining a certificate was simple. However for the new Project Area contact the process was unfamiliar and CDC point of contact intervention and trouble shooting was sometimes required.

By September 11, not all of the areas had obtained digital certificates. And there were still a number of Project Areas without a certificate when the event started. By the second reporting week, nearly everybody was set up appropriately.

In the area of communication there were six H1N1 Project Area update Webinars and training sessions during the pre-event period. The communication presented Project Areas with necessary information, updates for event success.

Also during this period, the Project Areas were assigned a new CDC point of contact for direct communication access. And timely updates were made to

the CRA Web page. So overall, we achieved our goals during the pre-event period.

Now I am going to talk about the event period. And as I stated earlier which lasted from October through November 21. We are going to talk about what was planned, what we expected to happen.

The points of contact were asked to submit counts of H1N1 vaccine doses administered for each reporting period based on the MMWR week. The deadline for reporting was Tuesdays by 11:59 pm of the Project Area's respective time zone.

We asked you to submit counts of H1N1 vaccine doses administered according to the age groups identified by the U.S. Government Health and Human Services. And we also asked you to submit dose number count category and that included whether it was a first vaccine, a second vaccine or an unknown.

So let's talk about what happened. For data submission of the 62 Project Areas, 57, which represented 92%, submitted data on time during the first week of the event period.

Just a couple of notes - we define timeliness as sending weekly aggregate data by 11:59 pm on Tuesday following the reporting week. By extended the weekly reporting deadline to mid afternoon on Wednesday, timeliness would increase to 100% by October 31 for all sites that had received vaccines.

Of the 62 Project Areas, 35 representing 56% had a completeness ratio of 75% or better. Completeness is defined as reporting all doses administered to date by 11:59 pm on Tuesday following the reporting week.

Over 90% of the Project Areas underreported doses administered the week following administration. And generally there was a two to four week lag in reporting all doses administered from previous weeks.

In the area of communication, the CRA points of contact were actively involved with their Project Area counterparts. They provided assistance throughout the event including answering questions, facilitating assistance when issues arose and providing technical support.

They send weekly reminder emails to the Project Area points of contact and made telephone calls to follow up with Project Areas who were unable to meet the Tuesday 11:59 pm reporting deadline. In some cases, the CRA points of contact helped submit doses administered data.

There were a number of Project Areas that contacted CDC with technical and other challenges. These included digital certificate issues. We heard from the different areas that the process was too long, that there were problems with download the certificate to the computer or in some cases folks had expired certificates.

With SDN, some Project Areas experienced problems accessing the CRA application to submit data because the secure data network was down and they were unable to access the system.

Some Option 1 users reported that they had file formatting issues. During the reporting period, a few Project Areas experienced challenges with reporting data on time. There were unavoidable reporting delays. Several Project Areas experienced treacherous weather conditions such as blizzard, tsunamis, hurricanes which prevented them from reporting data on time. And one

Project Area even had a bomb threat and was unable to meet the reporting deadline.

Some of the Project Areas had difficulties with their internal processors and operational logistics which prevented them from meeting CRA deadlines.

At this point, I would like to open up the lines and hear from all of you. We would like to hear about your experiences. We would like feedback, discussions, comments, questions. Please feel free to share openly both positive and negative comments, but remembering to maintain a level of respect for everyone on the call.

Thank you.

Coordinator: Thank you. We will now begin the question and answer session. If you would like to ask a question, please press star 1. You will be prompted to record your name. To withdraw your question you may press star 2. One moment please while we wait for the first question.

First question comes from Tony Aragon. Your line is open.

Tony Aragon: Will there be any data released statewide data, comparisons between the states?

Barb Nichols: There will be data released for each state but it will be straight data from your state. It will not be compared to other states. So each state will get a summary of their data.

Howard Hill: And there will be a metric of how your state compared to the national average. But you will not be compared to other state. I mean, it is just not fair. Don't

we have some metrics about each group don't we, Option 1, Option 2, Option 3 how they did within their own. And between option groups we will also be able to provide you with how you did within the method that you chose to report doses administered. So you will have some measurement there that is even a little closer.

Coordinator: Next question comes from Mike Rogers.

Mike Rogers: Hi. This is Mike Rogers up in New Hampshire and we were an Option 2, 3 state. And my question really is more of a curiosity question of why we stopped collecting data after we got started?

Tom Shimabukuro: Hi. This is Tom Shimabukuro. We always intended CRA to be our early system to track utilization, to see if we were hitting the appropriate age groups in this case for H1N1.

And as supplies began to get better throughout the course of the response, we began receiving reports and hearing some anecdotal evidence that reporting was becoming a burden and that it was possibly interfering with administering vaccine.

And as a result, some states even had big backlogs of reports that they hadn't submitted yet. And at that point, we had really hit our tipping point where we decided at the Federal level to stop the requirement for reporting.

Now I know a lot of Option 1 states still maintain their reporting requirements and we also did keep Option 3 open in case Option 3 states wanted to use that. But it was really that CRA, which again was our early system, had served its purpose we think pretty well. And it was time to really shift emphasis and take

that burden, take the reporting burden away from some of the states where it was becoming a burden and allow them to really focus on vaccinating.

Mike Rogers: Thank you.

Howard Hill: And too Tom, there are other systems that we count on later on in an event, right?

Tom Shimabukuro: Yes. We have the Behavioral Risk Factor Surveillance System and the National H1N1 Flu Survey which is really modeled after the National immunization survey but without the provider record check.

At about that point, we expected to start getting estimates of coverage in with a large enough sample size that the confidence intervals were reasonable. And that also contributed to the time when we decided to stop the Federal reporting requirement as well.

Coordinator: Next question comes from Cameron Minich.

Cameron Minich: Oh yes. This is Cameron Minich with the Indiana State Department of Health. We were an Option 1 state. Actually it wasn't so much a question, but we actually had very positive response with the system as far as how easy it was to upload the file to the system from our registry right into the system. And it seemed like it worked very, very well.

So I kind of just to reiterate what Mike was just saying from New Hampshire, yes. I mean we could have continued the process. I will say on one hand it was kind of nice to not have to send the file any longer, but in the same breath too it would have been just as easy to continue the process.

So, but for us it worked very, very well. We worked with Marella Bradway as far as getting everything set up - as far as the couple times we had an issue with our system not calculating the totals correctly. But other than that it worked very, very well.

Tom Shimabukuro: This is Tom. You are still requiring providers to report to your registry. Is that correct?

Cameron Minich: Oh yes. Yes. That is correct.

Tom Shimabukuro: Okay.

Cameron Minich: We will not come off on that. That is definitely a big requirement for us. And even so, the H1N1 vaccine that is now being directly given to our box stores, our chain drug stores from the CDC - they are still continuing to report to our registry as well.

Tom Shimabukuro: I assume that you have some reporting for seasonal vaccine because, you know, you have children that receive seasonal vaccines. It's a little bit different. You expanded it. Do you anticipate that your reporting rate or your response rate for lack of a better word is going to be greater for H1N1 than for seasonal?

Cameron Minich: Oh yes. Yes. Very much so. Our seasonal in the past historically, you know, we have only ever collected most of our seasonal information from our local health departments, our vaccines for children, suppliers so the people who were part of the vaccine for children program and then from our hospital systems.

But our smaller private systems, because there was not requirement for them to report the season, we never got as good a picture.

For H1N1 on the other hand, because of the requirements that we were able to include when we gave the vaccine out to the private facilities and such, well we've been getting a much, much better response, a much better picture of where all of the vaccine has gone exactly.

Tom Shimabukuro: And so for your adult providers, like internists, geriatricians, occupational health clinics...

Cameron Minich: Yes.

Tom Shimabukuro: ...retail pharmacies, what did you hear from them as far as - I mean this is new - pretty new to them.

Cameron Minich: As far as the reporting requirement goes?

Tom Shimabukuro: I mean how did they take it?

Cameron Minich: A lot of them, you know, are like nursing. We have elderly nursing facilities and things like that. A lot of them were already using our registry anyway for the PPV23 and some of the other vaccines are associated with that.

So for them it wasn't too difficult. The biggest push was probably the private facilities, the OB/GYN who had never used the registry before. They were kind of the ones to push back on us and say well we do not want to have to do this requirement and we really left it up to our local health departments to then decide either, you know, you give the vaccine to the OB clinics and you put the data in the system for them or you do not do them at all.

And when the locals kind of put it that way to those private providers, those private providers were very quick to get signed up and to use the registry because they did not want to be the provider who was not going to be able to give out the vaccine.

Tom Shimabukuro: Thanks.

Cameron Minich: Yes. No problem.

Howard Hill: Do you think the H1N1 activity will maintain some participation enthusiasm on the part of your private providers for seasonal?

Cameron Minich: Yes. Yes. We've already noticed that because we were surprised how many of those private providers that were coming on board to use the H1N1 asked us the question, well gee, can we also put our flu vaccine - can we put all of our other vaccines into the registry as well.

So we did see for this flu season we did see quite an increase in the amount of flu vaccines that were coming into the system as well.

Howard Hill: Excellent.

Coordinator: Next question comes from Tony Aragon.

Tony Aragon: I just wanted to get your opinion if you all thought state laws were acting as a barrier to reporting doses administered?

Tom Shimabukuro: Can you be a little more specific?

Tony Aragon: Well, like for example if - because this was considered a disaster, some state laws, I know here in Texas those disaster related vaccines are treated different than your normal vaccines. And because of that, there were some confidentiality issues that the data was treated a little bit different.

So, and then also as far as, you know, like you said before, the - that burden of reporting, especially on the provider, some state laws might enhance that burden. And I just wanted to get your feel if you felt like there was a barrier that some of those providers or states had to overcome because of those state laws and those reporting requirements that the shift of the importance of vaccinating was being shift over now to the importance of reporting instead of vaccinating.

Tom Shimabukuro: I didn't really too much about confidentiality laws at least at the state level. The Federal level is a different story. But at the state level, interfering or being a problem, I mean if you have a registry kind of by definition you report personal level information into their already. And I believe there are laws that allow that for vaccines.

For Option 2, at least the data coming to us was de-identified. Now that may have been collected at the state level. That personal identifying information may have been collected at the state level, just not transmitted to CDC. But we didn't hear any problems on that.

Then for Option 3 I do not think we did either. So I would be willing to bet that declaring a public health emergency may actually cause some states that may be reluctant to have that information collected be less reluctant to do that.

I know that we did some outreach to some of the states about VA and Department of Defense facilities. And the VA has some pretty strict rules and regulations about releasing information on veterans.

And we had to work through some of that with some of the states. Some of them they made it an opt-in or opt-out option. Some of them complied and we worked with some states to allow this reporting in the de-identified way.

But I mean if anything it was some of the Federal laws, privacy laws or privacy rules and regulations that were a burden, not really the state rules though.

Howard Hill: Also in every state, these issues of confidentiality of record released had already been supposedly and verbally have been addressed over several years in creation of the pan-flu plan as you have been going through for three or four years before we actually had a declared pandemic.

And those issues were all incorporated into every state's pandemic flu plan. So I do not think that declaring it a pandemic invoked any new laws that maybe states would be working under that had some issues because they were already agreed to I think in pretty much everybody's pan-flu plan as we have reviewed them.

Tony Aragon: Okay.

Coordinator: Once again if you would like to ask a question please press star 1.

Next question comes from Maureen Cassidy.

Maureen Cassidy: Hi. I don't really have a question. I just wanted to say that Oregon was an Option 1 user and everything went quite well. We had one problem transmitting but we, with the help of CDC, got everything fixed and transmitted on time. So, I was pleased. Thank you.

Barb Nichols: Thank you.

Howard Hill: Thanks Maureen.

Coordinator: Next question comes from Frank Caniglia.

Frank Caniglia: Yes good afternoon. From Pennsylvania - just a few comments. I think the overall logistical component that CDC provided was outstanding and the technical support was outstanding.

I do have a question with regards to future reporting such as what occurred this year. With the Meaningful Use efforts of that are going on, many registries could actually take advantage of this opportunity if CDC could promote this type of reporting from facilities through the HL7 interface.

I was wondering if there was any discussion at the CDC level to promote a hook if you will for public health pandemic reporting through the Meaningful Use.

Howard Hill: There are some things I've heard that are under discussion right now about some funding opportunities to support HL7, exchange improvements. But I can't say specifically. I have just on the peripheral heard this. I guess they are interest in that. And they are interested in trying to enhance it as far as we can with as many as we can as being the gold standard. But I cannot tell you specifically and I cannot tell you when.

Frank Caniglia: Okay thank you.

Warren Williams: Hey Frank this is Warren. I am in a different room than everybody else. But I just wanted to respond to your question. There is some movement to further advance some of the interoperability projects that registries have been involved in to help streamline the reporting and make it a bigger component of meaningful use. So we have been trying to work on that for a while and we are hopeful that something will happen with that to kind of take advantage of the meaningful use scenarios and initiatives that are out there to capitalize on the registry's experiences with interoperability and use of standard messaging formats, etcetera.

And that will primarily be for kind of the normal reporting approaches, but it has impact for emergency response issues also. So I just wanted to comment on that.

Coordinator: Next question comes from Jan Hicks-Thompson.

Jan Hicks-Thompson: Hi. This is Jan Hicks-Thompson from Washington State. I want to say from a technical perspective, I think the process worked really well for us. We allowed some flexibility for reports to come to us. We used Option 2 but we allowed providers to use methods that fit with their business practice to get doses administered reporting to us.

I think for us, one of the challenges and I am not sure if this is the exact forum to talk about it. In one of our challenges was just fitting the doses administered reporting into the context of our other vaccine accountability. For example inventory accountability which includes accounting for doses

administered, the differences in the age ranges that were used for reporting versus the age ranges of licensure for the vaccine products.

Some of those things that made the pieces not quite fit well together and from a holistic perspective of working with providers, we had a lot of questions, some confusion and challenges around that. So that is not a technical aspect of the process but something that we thought was very important.

Tom Shimabukuro: I can just say for Option 1 and Option 3, you were lucky in that you did not have to report an age interval because we just sort of calculated automatically. For Option 2, we pretty much adopted the age breakdown that the ACIP went with and which definitely is different for seasonal.

So that was the change. And that was I think a pretty significant change from what we planned for H5N1 where we actually were not even looking at age intervals. We were looking at priority groups.

So I can understand how that may have posed some challenges. Don't really know a way around that because we really had to collect the data based on the ACIP age intervals because that's how we were gauging if we were hitting those specific risk groups early on. But thanks for your comment.

Coordinator: Next question comes from Mike Rogers.

Juliet Fister: Yes. This is Juliet Fister. I am the IT Lead for this project. And I just wanted to bring up one thing that we thought was very significant and helpful. And that was we used offline CRA because we have so many remote sites.

And when we had an anthrax event up here, we were able to get it to use it or get it ready to use. We did not actually use it. But we were able to get it ready

to use very quickly. And of course with the help of the technical staff down there with Northrop Grumman, they were very helpful. But I like the product because of that. It made it very flexible.

Tom Shimabukuro: Could you describe how you would adapt it for - I assume this would be for distributing antibiotics?

Juliet Fister: Well no they were going to distribute antibiotics but also do vaccine to people that had been exposed already. So it would have been experimental. But what we did do was set up an event. And if we needed to go out to any site we could have gone out and just set up the event right there as well which is a real plus for something like this because if you have an event like we had that happened so suddenly, it really makes it much easier to work with.

Tom Shimabukuro: Uh-huh. Actually I think that flu may be one of the hardest diseases to work with for CRA because, I mean unlike smallpox or even anthrax where you may do some targeted intervention, for flu you are not really doing any target intervention. You are trying to vaccinate as many people as you can in as broadly across the U.S. as you can.

So, I think the fact that we were able to go from pretty much the early planning stages of an exercise to being fully functional in September I think is pretty remarkable.

And that certainly speaks to all the hard work that went on at the states and also with the CRA team here that helped pull this together as well.

Coordinator: Next question comes from Tony Aragon.

Tony Aragon: I just wanted to ask if there was any work done with the Immunization Safety Office there at CDC and VAERS. I am the VAERS Coordinator here and I know me and the CRA coordinator were all providing updates with each other. And I was just curious if there is any work done at your level there with the safety office.

Tom Shimabukuro: We certainly work with them. And in the early stages we were trying to get denominator data. And we knew that the CRA reporting was somewhat incomplete and somewhat delayed. And so I am not sure about this but I believe they look at all the data sources, the distribution data, the administration data, sort of came up with an estimate of what they thought was the denominator data.

I think that one of the things that the Immunization Safety Office would have been better tied in with CRA but the pandemic happened too soon. We never really got there.

I know that there are ways of linking in with VAERS not directly but pretty much linking into the electronic reporting or to the site that allows you to download and that VAERS report form.

But I have to say that our links between VAERS and CRA probably could have been better. I don't think we had enough time to actually develop those links. But who knows. I mean maybe for the next pandemic but hopefully that will not happen for a couple of decades.

Coordinator: Once again if you would like to ask a question, please press star 1.

Tom Shimabukuro: So we actually here at CDC have a couple questions we are hoping to get some feedback on. So the first question has to do with the PHIN help desk.

And the question is: do you think the role of the PHIN help desk was clearly conveyed? And that is really yes or no. And/or please provide an example of how your Project Area used the PHIN help desk.

So again, do you think the role of the PHIN help desk was clearly conveyed? And then please provide an example of how your Project Area used the PHIN help desk. And I am actually going to read all these question so you can queue up in the meantime.

The next question has to do with technical support and technical assistance. And it is: please share with us specific areas where CDC POCs could provide technical support or assistance to better assist you.

Again that is please share with us specific areas where the CDC POCs could provide technical support or assistance to better assist you.

The next question has to do with the Web site. And it reads, please give us examples of information that you would find helpful such as less text, different organization or structure on the CRA Web site.

Again, please give us examples of information that you would find helpful on the CRA Web site.

The next question has to do with the Webinars actually. It is: please provide us with your thoughts on the best structure for the weekly Webinars. And that could include the day, the time or the format. Again please provide us with your thoughts on the best structure for the weekly Webinars. And then finally the last question has to do with the previous exercises, the CRA exercises.

And that is how do you think CDC can better prepare Project Areas for future events as it relates to CRA reporting? Again how do you think CDC can better prepare Project Areas for future events as it relates to CRA reporting?

So I will stop now. You can queue up. And pretty much if you have any comments on any of those questions, we would be happy to hear them.
Thanks.

Coordinator: Okay. Our first question comes from Victor.

Victor Ilegbodu: Yes. Mark this is Victor Ilegbodu in Chicago. We are Option 2 and we are still using the reporting system up to date to get a doses administered from private providers. But my question is the pandemic is not over. What role does CRA see in the interim as the pandemic progresses as far as reporting or any of the activities involved in vaccine coverage for the H1N1?

Tom Shimabukuro: This is Tom. And I do not want to say shut down CRA but we at the Federal level stopped the reporting requirement. I believe it was about mid November. And at that point we no longer required states to report to us although we know that most Option 1 states still had their own reporting requirements.

The data that we got was we used internally here at CDC to see if we were hitting the age groups as laid out by the ACIP and the ACIP recommendations and informed the CDC leadership on how we were doing as far as doses administered.

And really after that point there really wasn't a direct role for CRA because we are in a transition period where we began to get data in from our population based surveys like the BRFSS and the national H1N1 flu survey.

So I will say that in the early part of the pandemic, the CRA was our initial system to track utilization. And in the latter part of the pandemic we really didn't use CRA at all at the Federal level because we were more focused on the coverage data.

However, we still think it is important to maintain CRA capability in case we have another pandemic and we do need to track doses administered again. So, the utility of the CRA is really focused on the very earliest part of a pandemic when vaccine is coming out in short supply and we want to make sure it is hitting those target groups that we have designated.

Coordinator: Next question comes from Mike Rogers.

Mike Rogers: Yes hi. We are talking up there with our group in New Hampshire, Julie Fister and Susan Bascom. And we just wanted to make a couple of comments.

First in terms of the CRA Web site, one of the things we kept chiming on was we wanted to see an improved functionality of reporting of the data in CRA. It was always our desire to see more options for pulling data out that we put into the system. And we are hoping to expand that menu of more functionality for the online CRA site.

The second point we wanted to make was in terms of the CRA exercises. I guess the only point I would make is that whatever improvements that are made from the user groups that to collaborate with from the different states that maybe the CRA exercises focus on those improvements and make sure they are doing what we intended them to do before it gets to the live date.

And lastly, the structure of the Webinars, I just wanted to touch on that real quickly. We like the interactive Webinars that actually show the functionality as we are going through it. And then again focusing on whatever improvements are made for reporting and different ways of capturing data. And that is all we have up here.

Tom Shimabukuro: Thanks.

Coordinator: Next question comes from Frank Caniglia.

Frank Caniglia: Yes. I would like to just comment on a couple of the questions that CDC is looking for some answers or thoughts from the grantees. With regards to the technical support staff, my experience in Pennsylvania was outstanding because we were one of the states early on that we were experiencing issues with the digital certificate that was installed.

And the dilemma that we were experiencing was more so related to the type of browser version that we were using in which the digital certificate was being hosted on the desktop. And unfortunately some of the Internet Explorer versions did not interact very well with the digital certificate. And it was the support staff, technical support staff from CDC and I believe even from Northrop Grumman that really stuck with us and supported us and worked through the issues and we were able to resolve the issues.

So kudos to everybody that was involved in that. I think that that is a huge help to grantees.

With regard to Webinars, I think the Webinars are an outstanding source for all grantees because I think it allows us to interact directly with our counterparts, with other grantees and work with CDC to improve the process.

So I think that is an awesome vehicle that you have implemented and do hope and have the desire that they would still continue.

With regards to future exercises, my only request from an operational perspective and from a program manager is that from year to year we improve the reporting capability but we do not change the data that needs to be submitted to a great extent that would cause hardship to grantees to tweak or modify in the event of a pandemic or a crisis that may occur.

We have been participating, I believe it is three or four years with this effort. And early on there were significant changes that caused us to go through some restructuring of our code. And unfortunately, I am sure all grantees are in the same position, we just cannot redirect resources quick enough to make the code changes and to be able to support the current year scope of work.

So, I would ask that we try to standardize the process year in and year out but improve what is the ultimate goal as far as reporting requirements are concerned. Thank you.

Coordinator: Once again if you would like to ask question please press star 1.

Next question or comment comes from Pat Hays-Moore.

Pat Hays-Moore: Yes. Good afternoon. Here in New Mexico, one of the things that I think would have really helped us a great deal in the pre-event phase up front would have been a strong statement from CDC regarding the necessity, not the desire but the actual necessity of strong collaboration between the immunization program, the preparedness programs and IT that was assisting in this.

There has always been an inference that CDC wants us at the state and project level to be working together. And those of us that are worker bees agree and enjoy working with one another. However, I think what would have facilitated some of that up front planning and actual implementation over time would have been a little bit stronger statements from a collaboration at the Federal level.

In other words, the preparedness folks saying just as much as the immunization folks were saying that this is a joint effort that needs to be worked by all.

That being said, I am certainly hoping that this After Action report leads to the other piece which is an improvement plan that really does talk to that and all of the other issues that have been brought up for making it stronger, better, so forth.

And that that post event if you will improvement plan gets into the hands of all three arenas. I think that will facilitate future exercises.

And last but certainly not least, New Mexico also would very much like to echo Mr. Rogers statement on the need to standardize the data elements and categories that we are reporting from year to year while aiming for improved reporting. That is all we had.

Barb Nichols: Thank you.

Coordinator: There are no further questions at this time.

Barb Nichols: Thank you. Again I want to thank all of you for participating in this call and for all of your participation with the H1N1 doses administered event. I would

like to remind you that we will be sending out a listserv of announcements giving you the specifics for the results sharing Webinar in February.

Once again we thank you for your wonderful comments and your feedback. And we appreciate you being on the line with us today.

Coordinator: This concludes today's conference. Please disconnect at this time.

END